John Elias Baldacci
Governor

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Commissioner

Maine Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011
Bureau of Medical Services

October 13, 2004

TO: Interested Parties

FROM: Christine Zukas-Lessard, Acting Director, Bureau of Medical Services

SUBJECT: Proposed Rule: MaineCare Benefits Manual, Section 45, Chapter III, Hospital Services

This rule proposes to modify reimbursement by capping increases in prospective interim payments (PIP); allowing PIP adjustments to reflect substantial changes in claims payments; calculating the inpatient discharge rate for acute care non-critical access hospitals by 1) determining a cost per discharge based on MaineCare cost reports for the hospital's fiscal year ending between October 1, 1998 and September 30, 1999, 2) inflating this cost per discharge to State fiscal year 2004, and 3), adjusting this rate down by a factor between .5 and .3 percent; allowing the negotiated rate for private psychiatric hospitals to be between 85 and 100% of charges; and clarifying information related to swing bed reimbursement and disproportionate share payments.

Should special accommodations at the scheduled hearing or a copy of the proposed rule be needed please call (207) 287-9368 or TTY (207) 287-1828 (Deaf/Hard of Hearing) or TTY 1-800-423-4331 (Deaf/Hard of Hearing) so accommodations can be made.

Rules and related rulemaking documents may be reviewed at and printed from the Bureau of Medical Services website at http://www.maine.gov/bms/MaineCareBenefitManualRules.htm or, for a fee, interested parties may request a paper copy of rules by contacting (207) 287-9368 or TTY: (207) 287-1828 or 1-800-423-4331.

Notice of Agency Rule-Making - Proposal

Agency: Department of Health and Human Services, Bureau of Medical Services

Chapter Number And Title: MaineCare Benefits Manual,
Chapter III, Section 45, Hospital Services.

Proposed rule number:

Concise Summary: This rule proposes to modify reimbursement by capping increases in prospective interim payments (PIP); allowing PIP adjustments to reflect substantial changes in claims payments; calculating the inpatient discharge rate for acute care non-critical access hospitals by 1) determining a cost per discharge based on Medicaid cost reports for the hospital's fiscal year ending between October 1, 1998 and September 30, 1999, 2) inflating this cost per discharge to State fiscal year 2004, and 3), adjusting this rate down by a factor between .5 and .3 percent; allowing the negotiated rate for private psychiatric hospitals to be between 85 and 100% of charges; and clarifying information related to swing bed reimbursement and disproportionate share payments.

See http://www.maine.gov/bms/MaineCareBenefitManualRules.htm for rules and related rulemaking documents.

This rule will ☐ will not ☒ have a fiscal impact on municipalities

Statutory Authority: 22 M.R.S.A., §42 §3173

Public Hearing: Date: November 1, 2004 Time: 9 AM

Location: Room 3
Department of Health and Human Services
442 Civic Center Drive
Augusta, ME 04333-0011

Deadline for Comments: 11/12/04

Agency Contact Person: Greg Nadeau

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SECTION 45 HOSPITAL SERVICES 1/1/85

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SECTION 45 HOSPITAL SERVICES 1/1/85

45.01 DEFINITIONS

45.01-1 **Acute Care Critical Access Hospital** is a hospital licensed by the Department as a critical access hospital that is being reimbursed as a critical access hospital by Medicare.

45.01-2 **Acute Care Non-Critical Access Hospital** is a hospital licensed by the Department as an acute care hospital that is not being reimbursed as a critical access hospital by Medicare.

45.01-3 **Discharge** is when ~~a when~~ a member is formally released from the hospital, transferred from one hospital to another, or dies in the hospital. For purposes of this Section, a member is not considered discharged if moved from one location within a hospital to another, or readmitted to the same hospital on the same day.

45.01-4 **Distinct Psychiatric Unit** is a unit within an acute care non-critical access hospital that specializes in the delivery of inpatient psychiatric services. The unit must be reimbursed as a distinct psychiatric unit as a subprovider on the Medicare cost report or must be comprised of beds reserved for use for involuntary commitments under the terms of a contract with the Department of Health and Human~~Behavioral and Developmental~~ Services. The claim must also be distinguishable as representing a discharge from a distinct psychiatric unit in the MaineCare claims processing system.

45.01-5 **MaineCare Paid Claims History** is a summary of all claims billed by the hospital to MaineCare for MaineCare eligible members that have been processed and accepted for payment by MaineCare.

45.01-6 **Private Psychiatric Hospital** is a hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment, and care of persons with mental illness and is privately ~~not~~ owned~~. and operated by the State of Maine.~~ The facility must be licensed as a psychiatric hospital by the Department of Health and Human Services. A psychiatric hospital may also be known as an institution for mental diseases.

45.01-7 **Prospective Interim Payment (PIP)** is the weekly payment made to a non-State owned hospital based on the estimated total annual Department obligation as calculated below. State owned hospitals ~~will~~ receive quarterly prospective interim payments. This payment may represent only a portion of the amount due the hospital; other lump sum payments may be made throughout the year. For purposes of the PIP calculation, a MaineCare discharge for the most recently completed ~~hospital~~ State fiscal year is one with a discharge date occurring within the ~~hospital~~ State fiscal year and submitted prior to the time of calculation.

45.01-8 **State Owned Psychiatric Hospital** is a hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment, and care of persons with mental illness and is owned and operated by the State of Maine. The facility must be licensed as a psychiatric hospital by the Department of Health and Human Services. A psychiatric hospital may also be known as an institution for mental disease.

45.01-9 **Transfer** means a member is moved from one hospital to the care of another hospital. MaineCare will not reimburse for more than two discharges for each episode of care for a member transferring between multiple hospitals.

45.02 GENERAL PROVISIONS

45.02-1 Inflation

For purposes of determining inflation, unless otherwise specified, the economic trend factor from the most recent edition of the "Health Care Cost Review" from Global Insight is~~hall be~~ used.

45.02-2 Third Party Liability (TPL)

When a member is admitted to a hospital ~~as a result of an accident~~, it is the hospital's responsibility to identify all coverage available and perform all procedural requirements of that identified coverage to assure proper reimbursement. Additionally, the hospital must notify the Bureau of Medical Services, Third Party Liability Unit. Only if MaineCare payment is sought, t~~T~~he hospital must include this information on the claim form; or if the information becomes known after claim submission, the hospital must notify the Unit in writing. This allows assignment of the member's right to third-party coverage of claims or possible recovery as the result of tort action. Please see Chapter I Section 1.07 for detailed definitions applicable to Third Party Liability. Providers must adhere to the procedures outlined in that Section.

Any MaineCare claim submitted by a hospital may only be withdrawn within 120 days of the date of the remittance ~~received~~statement.

45.02-3 Interim ~~Reconciliation~~ and Final Settlement

At ~~reconciliation~~interim and final settlement, the hospital will reimburse the Department for any excess payments; or the Department will reimburse the amount of any underpayment to the hospital. In either case, the lump sum payment must be made within 30 days of the date of the letter notifying the provider of the results of the year-end ~~reconciliation~~interim or final settlement. If more than one year's ~~reconciliation~~interim or final settlement is completed in the same proceeding, the net amount must be paid. If no payment is received within 30 days, the Department may offset prospective interim payments. Any caps imposed on PIPs are not applicable to

the determination of settlement amounts. The final settlement will not be performed until the Department receives the final Medicare cost report.

Note: Hospitals are required to file with the DHHS, Division of Audit a year-end cost report within 5 months from their fiscal year end. The cost report filing consists of: CMS Form 2552 or its equivalent, audited financial statements, and any other related documentation as requested by the DHHS-Division of Audit. The cost report must include applicable MaineCare utilization and a calculated balance due to/from MaineCare.

MaineCare will reimburse for services to the extent that aggregate payments do not not exceed federally mandated upper payment limits (UPL). If payments exceed the UPL, the Department will make proportionate reduction of reimbursement based on the hospital's Medicaid Utilization Rate as defined in Section 45.10.

45.02 **GENERAL PROVISIONS** (cont)

45.02-4 Crossover Payments

MaineCare does not reimburse for Medicare crossover payments.

45.03 **ACUTE CARE NON-CRITICAL ACCESS HOSPITALS**

45.03-1 **Prospective Interim Payment**

The Department of Health and Human Services' total annual PIP obligation to a hospital will be the sum of MaineCare's obligation for the following: inpatient services + outpatient services + inpatient capital costs + hospital based physician and graduate medical education costs + days awaiting placement. Third party liability payments are subtracted from the PIP obligation. This payment is capped at 117.5% of the weekly payment made in the previous State fiscal year, exclusive of any adjustment for high historical MaineCare costs. The computed amounts are calculated as described below:

A. **Inpatient Services**

1. **Acute Care Non-Critical Access Inpatient**

Effective July ~~April~~ 1, 2004 the rate per discharge was calculated by 1) determining a cost per discharge based on Medicaid cost reports for the hospital's fiscal year ending between October 1, 1998 and September 30, 1999; 2) inflating this cost per discharge to State fiscal year 2004; 3), adjusting this rate down by a factor between 1~~5~~ and 1.5~~6~~ percent~~, and 4) adjusting rates for hospitals with the highest historical total MaineCare inpatient reimbursement. This adjustment allocates legislatively~~

~~appropriated funds based on historical data reflecting share of total MaineCare reimbursement. This adjustment will be reviewed at least annually. An additional adjustment will be made to the discharge rate for hospitals with the highest historical total MaineCare inpatient reimbursement and distinct psychiatric unit to account for a miscalculation that occurred when setting rates for the period from August 1, 2003 through October 29, 2003.~~ This rate is then multiplied by the anticipated discharges for the State fiscal year, which are calculated as described in Section 45.01-7.

2. **Distinct Psychiatric Unit Inpatient**

Discharges from distinct psychiatric units will be reimbursed at the rate specified in Appendix A per discharge. MaineCare will only reimburse at this rate when the member has spent the majority of his or her stay in the distinct
unit. MaineCare will only reimburse for one discharge for a single hospital for one episode of care.

45.03 **ACUTE CARE NON-CRITICAL ACCESS HOSPITALS** (cont)

B. **Outpatient Services**

Effective July ~~April~~ 1, 2004 the MaineCare outpatient component of the PIP equals the lower of MaineCare outpatient costs or charges during the fiscal year for which the most recent interim cost-settled ~~as-filed cost~~ report as issued by DHHS Division of Audit, is available, inflated to the current State fiscal year and reduced by a factor of ~~2~~10%.

MaineCare's share of clinical laboratory and radiology costs are added to this amount. The procedure codes and terminology of the Healthcare Common Procedure Coding System (HCPCS) are used to establish MaineCare allowances for clinical laboratory and radiology services.

C. **Other Components~~Adjustments~~**

MaineCare's share of inpatient capital costs, inpatient and outpatient hospital based physician and graduate medical education costs, and inpatient and outpatient third party liability are taken from the most recent hospital fiscal year end MaineCare interim cost- settled report as issued by ~~filed with~~ DHHS Division of Audit, inflated to the current State fiscal year.

D. **MaineCare Member Days Awaiting Placement (DAP) at a Nursing Facility (NF)**

Reimbursement will be made prospectively at the estimated statewide average rate per member day for NF services. The Department shall adopt the prospective statewide average rates per member day for NF services that are specified in the Principles of Reimbursement for Nursing Facilities, MaineCare Benefits Manual Chapter III, Section 67. The average statewide rate per member day shall be computed based on the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated for a hospital's fiscal year.

~~All of these data elements are taken from the most recent hospital fiscal year end MaineCare cost report as filed with DHS Division of Audit, inflated to the current year.~~

45.03-2 **Interim Volume Adjustment**

~~The hospital may request in writing, or~~ T~~t~~he Department may initiate~~,~~ a comparison of MaineCare claims data submitted in the first 150 days of the payment year to the projected number of discharges used in calculating the PIP. If there is a difference of at least 5% between the actual MaineCare inpatient volume and prospectively estimated MaineCare inpatient volume, an adjustment may, be made to the PIP using actual discharge data. The Department is under no obligation to adjust a PIP as a result of this comparison. An adjustment to the MaineCare outpatient component may be made at the same time using current outpatient cost to charge ratios.

45.03 **ACUTE CARE NON-CRITICAL ACCESS HOSPITALS** (cont)

45.03-3 ~~**Year End**~~ **Interim Settlement**

The Department of Health and Human Services' ~~year end~~ interim settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data source used for inpatient calculations is ~~will be~~ discharges and charges included in MaineCare paid claims ~~history~~ history for the year for which settlement is being performed, as measured by the Department. Other calculations are ~~will be~~ based on the hospital's as-filed cost report and MaineCare paid claims history for the year for which ~~reconciliation~~interim settlement is being performed.

45.03-4 **Final Settlement**

The Department of Health and Human Services' final settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data source used for inpatient calculations will be discharges and charges

included in MaineCare paid claims history as measured by the Department. Other components will be based on the hospital's final ~~settled~~ cost report from the Medicare fiscal intermediary and MaineCare paid claims history for the year for which ~~reconciliation~~interim settlement is being performed.

45.04 **ACUTE CARE CRITICAL ACCESS HOSPITALS**

All calculations made in relation to acute care critical access hospitals must be made in accordance with the Tax Equity and Fiscal Responsibility Act (TEFRA), except as stated below, plus a DSH adjustment payment for eligible hospitals.

45.04-1 **Prospective Interim Payment**

The Department of Health and Human Services' total annual PIP obligation to the hospitals will be the sum of MaineCare's obligation of the following: inpatient services + outpatient services + days awaiting placement + hospital based physician + graduate medical education costs. Third party liability payments are subtracted from the PIP obligation. This payment is capped at 117.5% of the weekly payment made in the previous State fiscal year.

These computed amounts are calculated as described below:

A. **Inpatient Services**

Effective April 1, 2004, MaineCare will reimburse for 101% of the total MaineCare inpatient operating costs from the most recent interim ~~as-filed~~ cost-settled report, as issued by DHHS, Division of Audit, inflated forward to the current State fiscal year. ~~$250,000 will be allocated among the critical access hospitals based on their relative share of Medicaid utilization as compared to other critical access hospitals.~~

45.04 **ACUTE CARE CRITICAL ACCESS HOSPITALS** (cont)

B. **Outpatient Services**

Effective April 1, 2004, MaineCare will reimburse for 101% of MaineCare outpatient costs inflated to the current State fiscal year using the most recent ~~as-filed~~ interim cost-settled report, as issued by DHHS Division of Audit.

C. **MaineCare Member Days Awaiting Placement at a Nursing Facility**

Reimbursement will be made prospectively at the estimated statewide average rate per member day for NF services. The Department shall adopt the prospective

statewide average rates per member day for NF services that are specified in the Principles of Reimbursement for Nursing Facilities, MaineCare Benefits Manual Chapter III, Section 67. The average statewide rate per member day shall be computed based on the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated for a hospital's fiscal year.

D. **Other Components ~~Adjustments~~**

MaineCare's share of hospital based physician + graduate medical education costs are taken from the most recent hospital fiscal year end MaineCare interim cost-settled report as issued by ~~filed with~~ DHHS Division of Audit, inflated to the current State fiscal year.

45.04-2 **Interim Volume Adjustment**

~~The hospital may request in writing, or t~~The Department may initiate, a comparison of MaineCare claims data submitted in the first 150 days of the payment year to the projected number of discharges used in calculating the PIP. If there is a difference of at least 5% between the actual MaineCare inpatient volume and prospectively estimated MaineCare inpatient volume, an adjustment may be made to the PIP using actual discharge data. An adjustment to the MaineCare outpatient component may be made at the same time using current outpatient cost to charge ratios. The Department is under no obligation to adjust a PIP as a result of this comparison.

45.04-3 **~~Year End~~ Interim Settlement**

The MaineCare ~~year end~~ interim settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data sources used is~~will be~~ the hospital's as-filed cost report and MaineCare paid claims history for the year for which ~~reconciliation~~interim settlement is being performed.

45.04-4 **Final Settlement**

The Department of Health and Human Services' final settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data sources used will be the hospital's final ~~settled~~ cost report from the Medicare fiscal

45.04 **ACUTE CARE CRITICAL ACCESS HOSPITALS** (cont)

intermediary and MaineCare paid claims history for the year for which settlement is being performed.

45.05 **PRIVATE PSYCHIATRIC HOSPITALS**

45.05-1 **Prospective Interim Payment**

Private ~~Non-state-owned~~ psychiatric hospitals will be paid weekly prospective interim payments based on the Department's estimate of the total annual obligation to the hospital. The rate will be negotiated and will become effective at the beginning of the state's fiscal year. The Department's total annual obligation shall be computed based on the hospital's negotiated percentage rate. ~~Effective March 1, 2004, t~~The negotiated percentage rate shall be between ~~90~~85% and 100% of the hospital's estimated inpatient and outpatient charges, less third party liability. The hospital must notify the Department 60 days prior to any increase in its charges.

If the hospital increases charges subsequent to the annual adjustment, the hospital and the Department will meet to consider the extent that the increase in charges will affect the amount paid by MaineCare and to negotiate the amount by which the previously negotiated percentage of charges must be adjusted to account for the impact. If the hospital commences any new MaineCare covered service, whether or not subject to CON review, the parties will separately negotiate the percentage of charges to be paid by MaineCare for that service.

Special circumstances may arise during the course of a year that may warrant reconsideration and adjustment of the negotiated rate. These circumstances could include changes in psychiatric bed capacity or patient populations within the State that materially impact MaineCare or uncompensated care volume, extraordinary increases in charges, legislative deappropriation, MaineCare deficits that may result in decreased State funding, as well as other special circumstances that the parties cannot now foresee.

~~45.05-2 **Interim Volume Adjustment**~~

~~The hospital may request in writing, or the Department may initiate, a comparison of MaineCare charges on claims submitted in the first 150 days of the payment year to the projected charges used in calculating the PIP payment If there is a difference of at least 5% between the actual MaineCare inpatient charge data and prospectively estimated MaineCare charge data, an adjustment may be made to the PIP using actual charge data. An adjustment to the MaineCare outpatient component may be made at the same time using current outpatient charge data.~~

45.05-~~3~~2 **~~Year End~~ Interim Settlement**

The MaineCare ~~year end~~ interim settlement with a hospital is calculated using the same methodology and negotiated percentage rate as is used when calculating the PIP, except that the data sources used is ~~will be~~ the hospital's as-filed cost report and MaineCare paid claims history for the year for which ~~reconciliation~~interim settlement is being performed.

45.05 **PRIVATE PSYCHIATRIC HOSPITALS** (cont)

45.05-~~4~~3 **Final Settlement**

The Department's total annual obligation to a hospital will be computed based on the hospital's negotiated percentage rate. ~~Effective March 1, 2004, T~~the settlement amount shall be the negotiated percentage rate established under Section 45.05-1 for the pertinent
payment year, which shall be a percentage that is greater than or equal to ~~90~~85% percent but not more than 100% of the hospital's actual MaineCare charges from paid claims history, less third party liability.

Note: The Department retains the right to reopen and modify cost settlement(s) affecting the timeframe from October 1, 2001 forward to assure consistency with the State Plan in effect for the time period covered by the settlement.

45.06 **STATE OWNED PSYCHIATRIC HOSPITALS**

Effective July 1, 2003 the following methodology is in place:

45.~~ 05~~6-1 **Prospective Interim Payment**

Effective July 1, 2003 the MaineCare~~'~~ total annual PIP obligation to the hospitals will be the sum of MaineCare's obligation of the following: inpatient services + outpatient services + days awaiting placement + hospital based physician + graduate medical education costs + estimated DSH obligation. Third party liability payments are subtracted from the PIP obligation.

These computed amounts are calculated as described below:

A. **Inpatient Services**

The total MaineCare inpatient operating costs from the most recent interim ~~as-filed~~ cost-settled report as issued by DHHS Division of Audit, inflated forward to the current State fiscal year.

B. **Outpatient Services**

MaineCare outpatient costs inflated to the current State fiscal year using the most recent ~~as-filed~~ interim cost-settled report as issued by DHHS Division of Audit.

C. **MaineCare Member Days Awaiting Placement at a Nursing Facility**

Reimbursement will be made prospectively at the estimated statewide average rate per member day for NF services. The Department shall adopt the prospective statewide average rates per member day for NF services that are specified in the Principles of Reimbursement for Nursing Facilities, MaineCare Benefits Manual Chapter III, Section 67. The average statewide rate per member day shall be

computed based on the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated for a hospital's fiscal year.

45.06 **STATE OWNED PSYCHIATRIC HOSPITALS** (cont)

D. **Other Components ~~Adjustments~~**

MaineCare's share of hospital based physician + graduate medical education costs are taken from the most recent hospital fiscal year end MaineCare interim cost-settled report as issued ~~filed with~~ by DHHS Division of Audit, inflated to the current year.

45.~~05~~06-2 **Interim Volume Adjustment**

~~The hospital may request in writing, or~~ The Department may initiate a comparison of MaineCare claims data submitted in the first 150 days of the payment year to the projected number of discharges used in calculating the PIP. If there is a difference of at least 5% between the actual MaineCare inpatient volume and prospectively estimated MaineCare inpatient volume, an adjustment may be made to the PIP using actual discharge data. An adjustment to the MaineCare outpatient component may be made at the same time using current outpatient cost to charge ratios. The Department is under no obligation to adjust a PIP as a result of this comparison.

45.~~05~~06-3 ~~**Year End**~~ **Interim Settlement**

The MaineCare ~~year end~~ interim settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data sources used will be the hospital's as-filed cost report and MaineCare paid claims history for the year for which ~~reconciliation~~interim settlement is being performed.

45.06-4 **Final Settlement**

The MaineCare final settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data sources used will be the hospital's final ~~settled~~ cost report from the Medicare fiscal intermediary and MaineCare paid claims history for the year for which settlement is being performed.

~~**45.07 NF SERVICES PROVIDED TO MEMBERS IN A SWING BED**~~

~~Reimbursement will be made prospectively at the estimated statewide average rate per member day for NF services. The Department shall adopt the prospective statewide average rates per member day for NF services that are specified in the Principles of Reimbursement for Nursing Facilities, MaineCare Benefits Manual Chapter III, Section 67. The average statewide rate per member day shall be computed based on the simple average of the NF rate per member day for the applicable~~ State fiscal ~~year(s) and prorated for a hospital's fiscal year.~~

~~All of these data elements are taken from the most recent hospital fiscal year end MaineCare cost report as filed with DHS Division of Audit, inflated to the current year.~~

45.~~08~~07 **OUT-OF-STATE HOSPITALS**

The Department will reimburse out-of-state hospitals for inpatient and outpatient services based on:

1. The MaineCare rate if applicable;
2. The lowest negotiated rate with a payor whose rate the provider currently accepts;
3. The provider's in-State Medicaid rate;
4. A percentage of charges; or
5. A rate specified in MaineCare's contract with the provider.

Except as otherwise specifically provided in the agreement between MaineCare and the out-of-state provider, out-of-state providers must accept MaineCare reimbursement for inpatient services as payment in full for all services necessary to address the illness, injury or condition that led to the admission.

Out-of-State providers must meet all requirements outlined in Chapter I of the MaineCare Benefits Manual (MBM) including signing a provider/supplier agreement, obtaining prior authorization and those related to assignment and recovery of third party collections, when applicable. Providers are also subject to requirements outlined in MBM Chapter II, Section 45, Hospital Services and Section 46, Psychiatric Facility Services, as applicable.

45.~~09~~08 **CLINICAL LABORATORY AND RADIOLOGY SERVICES**

Hospital laboratory services provided to a person not currently a patient of the hospital are considered outpatient hospital services and are reimbursable in accordance with MBM Chapter II, Section 55, Laboratory Services, or Chapter III, Section 90, Physician Services.

In the case of tissues, blood samples or specimens taken by personnel that are not employed by the hospital but are sent to a hospital for performance of tests, the tests are not considered outpatient hospital services since the individual does not receive services directly from the hospital.

Certain clinical diagnostic laboratory tests must be performed by a physician and are, therefore, exempt from the fee schedule. Updated lists of exempted tests are periodically sent to hospitals from Medicare.

Laboratory services must comply with the rules implementing the Clinical Laboratory Improvement Amendments (CLIA 88) and any applicable amendments.

Hospital imaging services provided to a person not currently a patient of the hospital are considered outpatient hospital services and are reimbursable in accordance with MBM Chapter II, Section 101, Medical Imaging Services, or Chapter III, Section 90, Physician Services.

45.~~10~~09 DISPROPORTIONATE SHARE ~~HOSPITALS~~ (DSH) PAYMENTS

"Payment Year" for purposes of determining DSH eligibility calculations means a year commencing on or after October 1st. However, if a hospital has a fiscal year which commences between September 20 and September 30, then its fiscal year shall be deemed to be a fiscal year commencing October 1st of the same calendar year. For example, if a hospital's fiscal year ends September 25, its fiscal year shall be deemed to be a fiscal year commencing October 1 of that calendar year.

45.~~10~~09 DISPROPORTIONATE SHARE ~~HOSPITALS~~ (DSH) PAYMENTS (cont)

45.~~10~~09-1 Eligibility for DSH Payments

In addition to specific requirements listed below, to be eligible for DSH payments all hospitals must:

i) have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Plan. In the case of a hospital located in a rural area that is an area outside of a Metropolitan Statistical Area (MSA) as defined by the Executive Office of Management and Budget the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

ii) the obstetric criteria in subsection i above, do not apply to hospitals in which the inpatients are predominantly individuals under 18 years of age or to hospitals that did not offer non-emergency obstetric services as of December 21, 1987.

A. Essential Non-State Public Acute Hospitals

A hospital must meet all of the following criteria, as determined by the Department:

1. The hospital is a non-State owned, publicly owned hospital;

2. The hospital is a licensed acute hospital located in the State of Maine; ~~and~~

3. The hospital has a current MaineCare provider agreement; and~~.~~

4. The hospital must have a Medicaid Utilization Rate (MUR) of at least 1%, as defined below.

B. **Institutions for Mental Diseases**

The IMD must have a MaineCare utilization rate ~~(MUR~~) of at least one percent.

C. **Acute Care Hospitals, other than Essential Non-State Public Acute Hospitals**

To be eligible for a DSH payment the hospital must either a) have a MaineCare inpatient utilization rate at least one standard deviation above the mean MaineCare inpatient utilization rate for hospitals receiving MaineCare payments in the state (as defined in section 1923 b1A of the SSA), or b have a low income inpatient utilization rate, (as defined in section 1923 b1b, of the Social Security Act) exceeding 25%.

For purposes of determining whether a hospital is a disproportionate share hospital in a payment year the Department will use data from the hospital's Medicare final cost report for the same period to apply the standard deviation test. Final settlement reports for the specified payment year must be issued by the Department for all acute care hospitals in order for DSH to be calculated and paid by the Department.

45.~~10~~09**DISPROPORTIONATE SHARE ~~HOSPITALS~~ (DSH) PAYMENTS** (cont)

~~The acute care hospital must meet the criteria in Section 45.01-9(1)(a) and (b) have a MaineCare utilization rate of at least 25%.~~

D. **Calculation of MaineCare Utilization Rate (MUR)**

The MaineCare utilization rate calculation is:

MUR % = 100 X M/T
M = Hospital's number of inpatient days attributable to MaineCare covered patients
T = Hospital's total inpatient days

In calculating the inpatient MUR, the Department ~~State~~ will include newborn nursery days, whether billed under the mother's MaineCare identification number or the infant's, days in specialized wards, including intensive and critical care units, administratively necessary days including days awaiting placement, and days attributable to individuals eligible for Medicaid in another state**.** The Department ~~State~~ will not include days attributable to MaineCare members between 21 and 65 years of age in institutions for mental diseases, unless such days are reimbursable under MaineCare.

45.~~10~~09-2 **~~Prospective~~ Disproportionate Share ~~DSH~~ Payments**

Subject to the Cap Adjustment described below and to the extent allowed by the Centers for Medicare and Medicaid Services (CMS), unless otherwise provided, the DSH adjustment will be 100% of the actual cost, as calculated using TEFRA and GAAP principles, of:

1. services furnished to MaineCare members plus,
2. bad debt and charity care as reported on the hospital's most recent audited financial statement plus,
3. cost associated with the downsizing of the State-run facilities, if applicable; minus
4. payments made by the State for services furnished to MaineCare members.

For the essential non-State public acute care hospitals the DSH adjustment for services rendered during the period August 1, 2003 through June 30, 2005 will be 175% of applicable costs, minus state payments.

Cap Adjustment

The Centers for Medicare and Medicaid Services establishes an aggregate cap on the DSH payment for which the State may claim federal financial participation (overall cap). Within that overall aggregate cap, there is a limit on the amount of DSH payment that may be made to IMDs (IMD cap).

45.~~10~~09 **DISPROPORTIONATE SHARE ~~HOSPITALS~~ (DSH) PAYMENTS**(cont)

1. IMD DSH Payments

   If the Department determines that aggregate payments, as calculated above, would exceed the IMD cap established by CMS, payments will be made to State-run
   facilities first. Remaining IMD DSH payments will be proportionately reduced for all remaining IMDs.

2. Acute Care DSH Payments

If the Department, determines that aggregate payments to acute care hospitals, as calculated above, would exceed the overall cap established by CMS, less DSH payments to IMDs, then:

The Department will determine the amount of DSH allotment necessary to establish budget neutrality for any applicable federal waivers. After making this determination, the Department will use the remainder of the allotment, if any, to make DSH payments to essential non-State public acute care hospitals. If necessary, DSH payments to these facilities will be proportionately reduced. Remaining acute care DSH payments will be proportionately reduced for all remaining hospitals.

3. Proportionate Reduction

The allowable DSH available will be allocated among the DSH eligible hospitals based on their relative share of applicable DSH payments absent the cap. ~~Department will calculate the proportionate reduction by applying the original DSH payment percentage determined for each hospital to the applicable DSH payment amount (cap) available.~~

45.~~10~~09-3**Final DSH Adjustment for Essential Non-state Public Acute and Psychiatric Hospitals**

The Department of Health and Human Services' total year end DSH obligation to a hospital is calculated using the same methodology as is used when calculating the initial ~~prospective~~ DSH adjustment, except that the data source used will be the hospital's final ~~settled~~ cost report data, audited financial statement, and actual MaineCare claims from paid claims history for the year for which ~~reconciliation~~interim settlement is being performed.

Appendix A
Psychiatric Unit Rate

Hospital	**State FY 2004 Psych Unit Rate**
Central Maine Medical Center	NA
Eastern Maine Medical Center	NA
Maine Medical Center	$~~5~~,~~5~~6,600
Maine General Health	$~~5~~,~~5~~6,600
Mercy (inc Westbrook)	NA
Saint Mary's	$~~5~~,~~5~~6,600
Southern Maine Medical Center	$~~5~~,~~5~~6,600
Bridgton Hospital (inc No Cumberland)	NA
Cary Medical Center	NA
Downeast Community	NA
Henrietta D Goodall	NA
Houlton Regional	NA
Inland Hospital	NA
Maine Coast Memorial	NA
Mid Coast Hospital	$~~5~~,~~5~~6,600
Miles Memorial	NA
Northern Maine	$16,072.80 ~~13,394~~
Parkview Memorial	NA
Redington-Fairview General	NA
Saint Joseph's	NA
Sebasticook Valley	NA
Waldo County General	NA
York	NA
Franklin Memorial	NA
Mayo Regional	NA
New England Rehab	NA
Penobscot Bay	$~~5~~,~~5~~6,600
Stephens Memorial	NA
The Aroostook Medical Center	$~~5~~,~~5~~6,600